The California Managed Risk Medical Insurance Board
1000 G Street, Suite 450
Sacramento, CA 95814
(916) 324-4695 FAX: (916) 324-4878

December 24, 2008 R-5-08

ADVANCE NOTICE OF INTENT TO FILE EMERGENCY REGULATIONS

This notice is sent in accordance with Government Code Section 11346.1(a) (2), which requires that State of California agencies give a five working day advance notice of intent to file emergency regulations with the Office of Administrative Law (OAL). The Managed Risk Medical Insurance Board ("Board") intends to file an Emergency Rulemaking package with the Office of Administrative Law (OAL), providing authority for an increase in cost sharing in regards to monthly family contributions and to revise the Healthy Families Program vision and dental benefit structure. As required by subdivisions (a)(2) and (b)(2) of Government Code Section 11346.1, this notice appends the following: (1) the specific language of the proposed regulation and (2) the Finding of Emergency, including specific facts demonstrating the need for immediate action, the authority and reference citations, the informative digest and policy statement overview, attached reports, and required determinations.

The Board plans to file the Emergency Rulemaking package with OAL at least five working days from the date of this notice. If you would like to make comments on the Finding of Emergency or the proposed regulations (also enclosed), they must be received within five calendar days of the Board's filing at OAL by both the Board and the Office of Administrative Law. Responding to comments at this point in the process is strictly at the Board's discretion.

Comments should be sent simultaneously to:

Managed Risk Medical Insurance Board
Attn: Dianne Knox, ER-5-08
1000 G Street, Suite 450
Sacramento, CA 95814

And

Office of Administrative Law
300 Capitol Mall, Suite 1250
Sacramento, CA 95814

Please note that this advance notice and comment period is not intended to replace the public's ability to comment once the emergency regulations are approved. The Board

will hold a pubic hearing and 45-day comment period within the 180 day certification period following the effective date of the emergency regulations.

Please contact Dianne Knox at 916-324-0592 or dknox@mrmib.ca.gov if you have any question concerning this Advance Notice.

Enclosures

FINDING OF EMERGENCY

Emergency Regulations for Healthy Families Program Family Contributions and Scope of Vision and Dental Benefits

At its December 17, 2008 meeting, the Managed Risk Medical Insurance Board (MRMIB) found that an emergency exists and that the immediate adoption of the enclosed regulations is necessary to avoid serious harm to the public peace, health, safety, or general welfare. A copy of the Finding of Emergency adopted by the Board is attached.

SPECIFIC FACTS DEMONSTRATING THE NEED FOR IMMEDIATE ACTION

Sections 17, 18 and 19 of Assembly Bill 1183 (Chapter 758, Statutes of 2008), amended the Healthy Families Program (HFP) statutes (Insurance Code section 12693 et. seq.) to increase monthly family contributions and revise the HFP vision and dental benefit structure. These sections also clarify that the adoption of conforming regulations by MRMIB is deemed to address an emergency for purposes of sections 11346.1 and 11349.6 of the Government Code.

AUTHORITY AND REFERENCE CITATIONS

Authority: Insurance Code sections 12693.21, 12693.43(i), 12693.63(d)(2) and 12693.65(d)

Reference: Insurance Code sections 12693.43(b)(2), 12693.43(b)(3)(B), 12693.43(d)(2), 126963.43(d)(3)(B), 12693.63 (d)(1) and 12693.65(b)

INFORMATIVE DIGEST AND POLICY STATEMENT OVERVIEW

Policy Statement: The objective of the proposed action is to implement, interpret, or make specific Sections 17, 18 and 19 of Assembly Bill 1183 (Chapter 758, Statutes of 2008) in regards to monthly family contributions, and vision and dental benefits.

Existing Law: The Insurance Code (commencing at section 12693) creates the HFP and sets forth, among other things, certain health, dental and vision benefits that can be provided to eligible families and certain amounts that are to be paid as family contributions for the provision of such benefits. These statutes are implemented, interpreted or made more specific by MRMIB. The specific amount, scope and duration of benefits, and the family contributions are currently set in regulations found at title 10, California Code of Regulations, beginning with section 2699.6700. The proposed action amends these provisions in keeping with Sections 17, 18 and 19 of Assembly Bill 1183 (Chapter 758, Statutes of

2008) which require increases in the family contributions, limits vision benefits and allows for a limitation on dental benefits.

A summary of the proposed regulations' effect on existing law and regulations is as follows:

Article 3. Health, Dental and Vision Benefits

Section 2699.6707

Section 2699.6707 describes the annual or lifetime benefit maximums.

Section 2699.6707(a) restates the same provisions contained in present section 2699.6707. In light of the addition of the provisions contained in section 2699.6707(b), for purposes of clarity, the provisions are placed into subsection (a).

Section 2699.6707(b) is being added to limit the covered dental benefit for each subscriber to fifteen hundred dollars ($1,500) per benefit year effective July 1, 2009. It is also being amended to clarify that dental benefits covered under the California Children's Services program are not subject to the $1,500 limitation.

Section 2699.6707 Reference Cited is being amended to include Insurance Code 12693.63.

Section 2699.6711

Section 2699.6711 describes the scope of dental benefits for subscriber parents.

Section 2699.6711(a) describes the basic scope of dental benefits and the limitations to the dental benefits for subscriber parents. It is being amended to limit the covered dental benefit for each subscriber to fifteen hundred dollars ($1,500) per benefit year effective July 1, 2009.

Section 2699.6721

Section 2699.6721 describes the scope of vision benefits for subscribers.

2699.6721(a)(2) is being amended to delete tinted and photochromic lenses.

Section 2699.6723

2699.6723 describes the vision benefits that are excluded from the HFP.

2699.6723(a)(10) is being added to clarify that tinted lenses and photochromic lenses, are excluded vision benefits unless otherwise deemed medically necessary.

2699.6723 (a)(10) – (14) are being renumbered to reflect the addition of the new section 2699.6723 (a) (10).

Section 2699.6725

Section 2699.6725 describes the share of cost of vision benefits for subscribers.

2699.6725(a)(2) is being amended to clarify the share of cost for tinted and photochromic lenses when they are otherwise deemed medically necessary.

2699.6725(b)(2)(F) describes the share of cost of vision benefits for subscribers as they relate to materials. It is being amended to clarify the share of cost for tinted and photochromic lenses when otherwise deemed medically necessary.

2699.6809 Determination of Family Contribution for the Program.

Section 2699.6809 describes the family contributions for the program.

Section 2699.6809(a)(1)(B) is amended to clarify that the current family contributions will stay in place through January 31, 2009, for families with an income of 150 up to and including 200% of the federal poverty level, and on and after February 1, 2009 will increase in conformity with subdivision (b)(2) of Insurance Code section 12693.43.

Section 2699.6809(a)(1)(C) is amended to clarify that the current family contributions will stay in place through January 31, 2009, for families with an income of 200 up to and including 250% of the federal poverty level, and on and after February 1, 2009 will increase in conformity with subdivision (d)(3)(B) of Insurance Code section 12693.43.

Section 2699.6809(a)(2)(B is amended to clarify that the current family contributions for families enrolled in the Community Provider Plan will stay in place through January 31, 2009, for families with an income of 150 up to and including 200% of the federal poverty level and on and after February 1, 2009 will increase in conformity with subdivision (d)(2) of Insurance Code section 12693.43.

Section 2699.6809(a)(2)(C)is amended to clarify that the current family contributions will stay in place through January 31, 2009, for families with an income of 200 up to and including 250% of the federal poverty level, and on and

after February 1, 2009 will increase in conformity with subdivision (d)(3)(B) of Insurance Code section 12693.43.

TECHNICAL, THEORETICAL, AND EMPIRICAL STUDY or REPORT

None.

DETERMINATIONS

The Proposed Substantial differentiation from existing comparable Federal Regulation or Statute: None

Mandates on Local Agencies or School Districts: None

Mandate Requires State Reimbursement Pursuant to Part 7 (commencing with section 17500) of Division 4 of the Government Code: None

Costs to Any Local Agency or School District that Requires Reimbursement Pursuant to Part 7 (commencing with section 17500) of Division 4 of the Government Code: None

Non-discretionary Costs or Savings Imposed on Local Agencies: None

Costs or Savings to Any State Agency:

- Premium Savings –

  The State will realize a savings of $2,216,393 in the current year due to increased subscriber premiums.

  The State will realize a savings of $5,630,242 in 2009-10 due to the increased subscriber premiums.

- Dental Benefits Savings –

  The State will not realize any savings in the current fiscal year due to the late signing of the 2008 Budget Act and implementation of this reduction has been delayed to 2009-10 Fiscal Year. Since it is unlikely that subscribers will reach the $1,500 benefit cap with only five months remaining in the benefit year assuming a February 1, 2009, implementation date, dental plan rates will not be reduced in 2008-09 as no reduction in utilization/costs is assumed.

The State estimates a General Fund savings of $1,941,430 savings in 2009-10 due to the implementation of the reduction.

Costs or Savings in Federal Funding to the State:

- Premium Savings –

  The Federal will realize a savings of $3,867,584 in the current year due to the increased subscriber premiums.

  The Federal will realize a savings of $9,824,718 in 2009-10 due to the increased subscriber premiums.

- Dental Benefit Savings –

  The Federal savings will not be realized in the current fiscal year due to the late implementation of the 2008 Budget Act and implementation of this reduction has been delayed to 2009-10 Fiscal Year.

  The Federal Funds savings in 2009-10 is estimated to be $3,316,075.

Costs or Savings to Individuals or Businesses:

There may be an increased cost to individuals as the proposed regulations implement a $1,500 dental benefits annual cap. Individuals may incur additional costs if their dental care exceeds the $1,500 cap. Subscribers will also pay a higher monthly premium.

STATE OF CALIFORNIA
MANAGED RISK MEDICAL INSURANCE BOARD
1000 G STREET, SUITE 450
SACRAMENTO, CA 95814

TITLE 10. INVESTMENT. CALIFORNIA CODE OF REGULATIONS
CHAPTER 5.8. MANAGED RISK MEDICAL INSURANCE BOARD
HEALTHY FAMILIES PROGRAM
AMEND SECTIONS 2699.6707; 2699.6709; 2699.6711; 2699.6721; 2699.6723; 2699.6725; and 2699.6809.

Text proposed to be added is displayed in underline type.
Text proposed to be deleted is displayed in ~~strikeout type.~~

ARTICLE 3: HEALTH, DENTAL AND VISION BENEFITS

Section 2699.6707 is amended to read:

2699.6707. Annual or Lifetime Benefit Maximums.

(a) There shall be no annual or lifetime financial benefit maximums in any of the coverage under the program.

(b) The covered dental benefit for each subscriber is limited to fifteen hundred dollars ($1,500) per benefit year effective July 1, 2009. The $1,500 limitation shall not apply to dental benefits provided to a subscriber under the age of 21 who is determined by the California Children's Services Program (Health and Safety Code Section 123800 et seq.) to be eligible for dental benefits under that program and the particular services are authorized by the California Children's Services Program for the particular subscriber for the treatment of a California Children's Services Program eligible medical condition.

NOTE: Authority cited: Section 12693.21, Insurance Code. Reference: Sections 12693.21, 12693.60, 12693.615, 12693.63, Insurance Code.

Section 2699.6711 is amended to read:

2699.6711. Scope of Dental Benefits for Subscriber Parents.

(a) The basic scope of benefits for subscriber parents offered by a participating dental plan must comply with all requirements of the Knox-Keene Health Care Service Plan Act of 1975, including amendments as well as its applicable regulations, and shall include all of the benefits and services listed in this section, subject to certain exclusions as listed in Section 2699.6713.

The covered dental benefit is limited to the benefit level for the least costly dentally appropriate alternative. If a more costly, optional alternative is chosen by the applicant, the applicant will be responsible for all charges in excess of the covered dental benefits.

The covered dental benefit for each subscriber is limited to fifteen hundred dollars ($1,500) per benefit year effective July 1, 2009.

No other dental benefits shall be permitted to be offered by a participating dental plan as part of the program. The basic scope of dental benefits shall be as follows:

(1) Diagnosis and Preventive Benefits

(A) Initial and periodic oral examinations – oral examinations are benefits only twice in a benefit year.

(B) Consultations, including specialist consultations

(C) Roentgenology, limited as follows:

1. Bitewing x-rays in conjunction with periodic examinations are limited to one series of four films in a benefit year.

2. Full mouth x-rays in conjunction with periodic examinations are limited to once in a three-year period unless special need is shown.

3. Panoramic film x-rays are limited to once in a three year period.

(D) Prophylaxis services, not to exceed two in a twelve month period.

A third cleaning will be provided as a benefit for high-risk patients in the following categories:

1. Women who are pregnant

2. Subscribers undergoing cancer chemotherapy

3. Subscribers with compromising systemic diseases such as diabetes as determined to be medically necessary for appropriate dental care by the provider and approved by the plan.

(E) Space maintainers, including removable acrylic and fixed band type.

(F) Preventive dental education and oral hygiene instructions

(2) Restorative Dentistry

(A) Restorations, limited as follows:

1. Amalgam, composite resin, acrylic, synthetic or plastic restorations for treatment of caries. If the tooth can be restored with such materials, any other restoration such as a crown or jacket is considered optional.
2. Composite resin or acrylic restorations in posterior teeth are optional.

3. Micro filled resin restorations which are noncosmetic

4. Replacement of a restoration is covered only when it is defective, as evidenced by conditions such as recurrent caries or fracture, and replacement is dentally necessary.

(B) Use of pins and pin build-up in conjunction with a restoration.

(C) Sedative base and sedative fillings.

(3) Oral Surgery

(A) Extractions, including surgical extractions.

(B) Removal of impacted teeth. Surgical removal of impacted teeth is a covered benefit only when evidence of pathology exists.

(C) Biopsy of oral tissues

(D) Alveolectomies

(E) Excision of cysts and neoplasms

(F) Treatment of palatal torus

(G) Treatment of mandibular torus

(H) Frenectomy

(I) Incision and drainage of abscesses

(J) Post-operative services including exams, suture removal and treatment of complications.

(K) Root recovery (separate procedure)

(4) Endodontics

(A) Direct pulp capping

(B) Pulpotomy and vital pulpotomy

(C) Apexification filling with calcium hydroxide

(D) Root amputation

(E) Root canal therapy, including culture canal, limited as follows.
Retreatment of root canals is a covered benefit only if clinical or radiographic signs of abscess formation are present,

and/or the patient is experiencing symptoms. Removal or retreatment of silver points, overfills, underfills, incomplete fills, or broken instruments lodged in a canal, in the absence of pathology is not a covered benefit.

(F) Apicoectomy

(G) Vitality tests

(5) Periodontics

(A) Emergency treatment, including treatment for periodontal abscess and acute periodontitis.

(B) Periodontal scaling and root planing, and subgingival curettage, limited as follows: Five quadrant treatments in any 12 consecutive months.

(C) Gingevectomy

(D) Osseous or Muco-Gingival Surgery.

(E) Periodontal procedures which include cleanings are subject to the limitations as described in Subsection 2699.6711(a)(1)(D).

(6) Crown, Jackets, Cast and Fixed Bridges

(A) Crowns, including those made of acrylic, acrylic with metal, porcelain, porcelain with metal, full metal, gold onlay or three-quarter crown, and stainless steel. Related dowel pins and pin build-up are also included. Crowns are limited as follows:

1. Replacement of each unit is limited to once every five years.

2. Crowns will be covered only if there is not enough retentive quality left in the tooth to hold a filling. For example, if the buccal or lingual walls are either fractured or decayed to the extent that they will not hold a filling.

3. Veneers posterior to the second biscupid are considered optional. An allowance will be made for a cast full crown.

(B) Fixed bridges, which are cast, porcelain baked with metal, or plastic processed to gold, are limited as follows:

1. Fixed bridges will be used only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, it is considered optional treatment.

2. A fixed bridge is covered when it is necessary to replace a missing permanent anterior tooth and the patient's oral health and general dental condition permits.

3. Fixed bridges used to replace missing posterior teeth are considered optional when the abutment teeth are dentally sound and would be crowned only for the purpose of supporting a pontic.

4. Fixed bridges are optional when provided in connection with a partial denture on the same arch.

5. Replacement of an existing fixed bridge is covered only when it cannot be made satisfactory by repair.

(C) The program allows up to five units of crown or bridgework per arch. Upon the sixth unit, the treatment is considered full mouth reconstruction which is an optional treatment.

(D) Recementation of crowns, bridges, inlays and onlays.

(E) Cast post and core, including cast retention under crowns.

(F) Repair or replacement of crowns, abutments or pontics.

(7) Removable Prosthetics

(A) Dentures, full maxillary, full mandibular, partial upper, partial lower, teeth, clasps and stress breakers, limited as follows:

1. Partial dentures are not to be replaced within five years unless:

a. It is necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible, there has been such an extensive loss of remaining teeth, or a change in supporting tissues, or

b. The denture is unsatisfactory and cannot be made satisfactory.

2. The covered dental benefit for partial dentures will be limited to the charges for a cast chrome or acrylic denture if this would satisfactorily restore an arch. If a more elaborate or precision appliance is chosen by the patient and the dentist, and is not necessary to satisfactorily restore an arch, the patient will be responsible for all additional charges.

3. A removable partial denture is considered an adequate restoration of a case when teeth are missing on both sides of the dental arch. Other treatments of such cases are considered optional.

4. Full upper and/or lower dentures are not to be replaced within five years unless the existing denture is unsatisfactory and cannot be made satisfactory by reline or repair, the plan determines that there has been such an extensive loss of remaining teeth, or a change in supporting tissue that the existing appliance cannot be made satisfactory.

5. The covered dental benefit for complete dentures will be limited to the benefit level for a standard procedure. The plan will pay the applicable percentage of the dentist's fee for a standard partial

or complete denture up to a maximum fee allowance (or established UCR fee). If a more personalized or specialized treatment is chosen by the patient and the dentist, the applicant will be responsible for all additional charges.

(B) Office or laboratory relines or rebases, limited to one per arch in any 12 consecutive months.

(C) Denture Repair

(D) Denture adjustment

(E) Tissue conditioning, limited to two per denture

(F) Denture duplication

(G) Implants (appliances inserted into bone or soft tissue in the jaw usually to anchor a denture) are covered.

(H) Stayplates – provided as a benefit only when used to replace extracted anterior teeth for adults during a healing period.

(8) Other Dental Benefits

(A) Local anesthetics

(B) Oral sedatives when dispensed in a dental office by a practitioner acting within the scope of their licensure.

(C) Nitrous oxide when dispensed in a dental office by a practitioner acting within the scope of their licensure.

(D) Emergency treatment, palliative treatment.

(E) Coordination of benefits with subscriber's health plan in the event hospitalization or outpatient surgery setting is medically appropriate for dental services.

(9) This part shall not be construed to prohibit a dental plan's ability to impose cost control mechanisms. Such mechanisms may include

but are not limited to requiring prior authorization for benefits or providing alternative treatments or services.

(10) Participating dental plans shall be responsible for identifying subscribers under the age of 21 who have conditions for which they may be eligible to receive services under the California Children's Services (CCS) Program and shall refer these individuals to the local CCS Program for determination of eligibility. If a subscriber is determined by the CCS Program to be eligible for CCS benefits, participating dental plans shall provide primary care and services unrelated to the CCS eligible condition and shall ensure coordination of services between plan providers, CCS providers, and the local CCS program.

(b) (1) The scope of dental benefits shall also include all dental benefits which are covered under the California Children's Services program (Health and Safety Code Section 123800 et seq.), provided the subscriber meets the medical eligibility requirements of that program, as determined by that program.

(2) When a subscriber under the age of 21 is determined by the California Children's Services Program (Health and Safety Code Section 123800 et seq.) to be eligible for benefits under that program, a participating dental plan shall not be responsible for the provision of, or payment for, the particular services authorized by the California Children's Services Program for the particular subscriber for the treatment of a California Children's Services Program eligible medical condition. All other services provided under the participating dental plan shall be available to the subscriber.

(c) If, pursuant to any Workers' Compensation, Employer's Liability Law, or other legislation of similar purpose or import, a third party is responsible for all or part of the cost of dental services to treat any bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit or gain, the participating dental plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating dental plan is reimbursed for such services.

(d) Coverage provided under the Healthy Families Program is secondary to all other coverage, except Denti-Cal. Benefits paid under this Program are

determined after benefits have been paid as a result of a subscriber's enrollment in any other dental care program. If dental services are eligible for reimbursement by insurance or covered under any other insurance or dental care service plan, the participating dental plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating dental plan is reimbursed for such services.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.63, 12695.64 and 12693.755, Insurance Code

Section 2699.6721 is amended to read:

2699.6721. Scope of Vision Benefits.

(a) The basic scope of benefits offered by a participating vision plan must comply with all requirements of the Knox-Keene Health Care Service Plan Act of 1975, including amendments as well as applicable regulations, and shall include all of the benefits and services listed in this section, subject to the exclusions listed in Section 2699.6723. No other vision benefits shall be permitted to be offered by a participating vision plan as part of the program. The basic scope of vision benefits shall be as follows:

(1) Examinations: Each subscriber shall be entitled to a comprehensive vision examination, including a complete analysis of the eyes and related structures, as appropriate, to determine the presence of vision problems or other abnormalities as follows:

(A) Case history: Review of subscriber's main reason for the visit, past history, medications, general health, ocular symptoms, and family history.

(B) Evaluation of the health status of the visual system; including:

1. External and internal examination, including direct and/or indirect ophthalmoscopy;

2. Assessment of neurological integrity, including that of pupillary reflexes and extraocular muscles;

3. Biomicroscopy of the anterior segment of the eye, including observation of the cornea, lens, iris, conjunctiva, lids and lashes;

4. Screening of gross visual fields; and

5. Pressure testing through tonometry.

(C) Evaluation of refractive status, including:

1. Evaluation for visual acuity;

2. Evaluation of subjective, refractive, and accommodative function; and

3. Objective testing of a patient's prescription through retinoscopy.

(D) Binocular function test.

(E) Diagnosis and treatment plan, if needed.

(F) Examinations are limited to once each twelve month benefit period, beginning July first of each year.

(2) When the vision examination indicates that corrective lenses are necessary, each subscriber is entitled to necessary frames and lenses, including coverage for single vision, bifocal, trifocal, lenticular, ~~tinted, photochromic,~~ and polycarbonate lenses as appropriate.

Frames and lenses are limited to once each twelve month benefit period, beginning July first of each year.

(3) Contact lenses shall be covered as follows:

(A) Necessary contact lenses shall be covered in full upon prior authorization from the vision plan, for certain conditions. These conditions may include the following:

1. Following cataract surgery;

2. To correct extreme visual acuity problems that cannot be corrected with spectacle lenses;

3. Certain conditions of Anisometropia; and
4. Keratoconus.

(B) Elective contact lenses may be chosen instead of corrective lenses and a frame at a maximum benefit allowance of $110, which includes examinations, fittings and lenses.

(C) Contact lenses are limited to once each twelve month period, beginning July first of each year.

(4) A low vision benefit shall be provided to subscribers who have severe visual problems that are not correctable with regular lenses. This benefit requires prior approval from the participating vision plan. With this prior approval, supplementary testing and supplemental care, including low vision therapy as visually necessary or appropriate, shall be provided.

For subscriber parents, the covered person is required to pay a $5 copayment for any approved Low Vision services.

(5) Participating vision plans shall be responsible for identifying subscribers under the age of 21 who have conditions for which they may be eligible to receive services under the California Children's Services (CCS) Program and shall refer these individuals to the local CCS program for determination of eligibility. If a subscriber is determined by the CCS Program to be eligible for CCS benefits, participating vision plans shall provide services unrelated to the CCS eligible condition and shall ensure coordination of services between plan providers, CCS providers, and the local CCS program.

(b) (1) The scope of vision benefits shall also include all vision benefits which are covered under the California Children's Services Program (Health and Safety Code Section 123800 et seq.), provided the subscriber meets the medical eligibility requirements of that program, as determined by that program.

(2) When a subscriber under the age of 21 is determined by the California Children's Services Program to be eligible for vision

benefits under that program, a participating vision plan shall not be responsible for the provision of, or payment for, the particular services authorized by the California Children's Services Program for the particular subscriber for the treatment of a California Children's Services Program eligible medical condition. All other services provided under the participating vision plan shall be available to the subscriber.

(c) If, pursuant to any Workers' Compensation, Employer's Liability Law, or other legislation of similar purpose or import, a third party is responsible for all or part of the cost of vision services to treat any bodily injury or sickness arising from or sustained in the course of any occupation or employment for compensation, profit or gain, the participating vision plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating vision plan is reimbursed for such services.

(d) Coverage provided under the Healthy Families Program is secondary to all other coverage, except Medi-Cal. Benefits paid under this Program are determined after benefits have been paid as a result of a subscriber's enrollment in any other vision care program. If vision services are eligible for reimbursement by insurance or covered under any other insurance or vision care service plan, the participating vision plan shall provide the services at the time of need, and the subscriber or applicant shall cooperate to assure that the participating vision plan is reimbursed for such services.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.65, 12693.66 and 12693.755, Insurance Code.

Section 2699.6723 is amended to read:

2699.6723. Excluded Vision Benefits.

(a) A vision benefits plan offered under this program shall exclude:

(1) Any benefits specified as excluded within Section 2699.6721.

(2) Any benefits in excess of limits specified in Section 2699.6721.

(3) Services, supplies, items, procedures or equipment, which are not medically necessary as determined by the plan, unless otherwise specified in Section 2699.6721.

(4) Any benefits that were received prior to the subscriber's effective date of coverage.

(5) Any benefits that were received subsequent to the time the subscriber's coverage ends.

(6) Benefits that are not obtained in compliance with the rules and policies of the subscriber's vision plan.

(7) Orthopics or vision training and any associated supplemental testing.

(8) Aniseikonic lenses.

(9) Plano lenses.

(10) Tinted or photochromic lenses unless otherwise deemed medically necessary.

~~(10)~~(11) Two pairs of glasses in lieu of bifocals, unless medically necessary and with the prior authorization of the vision plan.

~~(11)~~(12) Replacement or repair of lost or broken lenses or frames.

~~(12)~~(13) Medical or surgical treatment of the eyes.

~~(13)~~(14) Eye examinations required as a condition of employment.

~~(14)~~(15) Any additional costs over and above the plan's frame allowance, as specified in subsections 2699.6725(a)(2) and 2699.6725(b)(2).

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code. Reference: Sections 12693.21, 12693.65 and 12693.755, Insurance Code.

Section 2699.6725 is amended to read:

2699.6725. Share of Cost for Vision Benefits.

(a) A participating vision plan shall require copayments for benefits provided to subscribers utilizing the services of the vision plan's panel of approved providers subject to the following:

(1) Examinations: $5 copayment per examination.

(2) Frames and lenses: $5 copayment, for frames with lenses, or for frames or lenses when purchased separately. No additional copayment for tinted~~,~~ or photochromic lenses when otherwise deemed medically necessary, or polycarbonate lenses.

A frame allowance of $75 is provided by the vision plan. The subscriber is responsible for any costs exceeding this allowance.

The following options are considered cosmetic and any costs associated with the selection of these options will be the financial responsibility of the applicant.

(A) Blended lenses (bifocals which do not have a visible dividing line);

(B) Contact lenses except as specified in Section 2699.6721(a)(3);

(C) Oversized lenses (larger than standard lens blank to accommodate prescriptions);

(D) Progressive multifocal lenses;

(E) Coated or laminated lenses;

(F) UV protected lenses.

(G) Other optional cosmetic processes.

(H) A frame that costs more than the plan's allowance.

(3) Necessary contact lenses, as defined in Subsection 2699.6721(a)(3): No copayment.

(4) Elective contact lenses: an allowance of $110 will be provided by the vision plan toward the cost of an examination, contact lens evaluation, fitting costs and materials. This allowance will be in lieu of all benefits including examination and material costs. The subscriber is responsible for any costs exceeding this allowance.

(5) Low vision benefits:

(A) Supplementary testing: No copayment; and
(B) Supplemental care: $5 copayment.

(b) Services from providers not included in the vision plan's panel of approved providers:

When a subscriber obtains services from a provider not included in the vision plan's panel of approved providers, the applicant will be responsible for paying the provider for all services and materials received at the time of their appointment. The participating vision plan will reimburse the applicant within fourteen (14) calendar days after receipt of the paid itemized bill or statement, according to the schedule of allowances as follows:

(1) Professional fees:

(A) Vision exams - up to $35.00

(2) Materials:

(A) Each single vision lens - up to $12.50 or a pair of single vision lenses up to $25.00.
(B) Each bifocal lens - up to $20.00 or a pair of bifocal lenses up to $40.00.

(C) Each trifocal lens - up to $25.00 or a pair of trifocal lenses up to $50.00.

(D) Each lenticular lens - up to $50.00 or a pair of lenticular lenses up to $100.00.

(E) Frame - up to $40.00

(F) Tinted or photochromic lenses when otherwise deemed medically necessary – up to $5.00

(G) Polycarbonate lenses - up to $10.00.

(H) Each pair of necessary contact lenses - up to $250.00

(I) Each pair of elective contact lenses - up to $110.00. Determination of whether contact lenses are necessary or elective when obtained from providers not included in the vision plan's panel of approved providers will be the responsibility of the vision plan. Reimbursement for elective contact lenses is in lieu of all benefits, including examination and materials.

(3) Low vision benefits: Low vision benefits obtained from a provider not included in the vision plan's panel of approved providers will be reimbursed in accordance with what the participating vision plan would pay a provider included in the vision plan's panel of approved providers for this benefit.

(c) No deductibles shall be charged to subscribers for vision benefits.

(d) For subscriber parents who receive vision services from one of the participating member doctors, covered services as described are provided with no additional out-of-pocket costs after an applicable copayment. Additional services selected for cosmetic purposes are the financial responsibility of the patient.

(e) No copayments shall apply if the applicant has submitted acceptable documentation as described in Section 2699.6600(c)(1)(GG) that the applicant or the subscriber is American Indian or Alaska Native. However, there is no limitation on the payments required under Subsection (b) above.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code.
Reference: Sections 12693.21, 12693.65 and 12693.755, Insurance Code.

ARTICLE 4. RISK CATEGORIES AND FAMILY CONTRIBUTIONS

Section 2699.6809 is amended to read:

2699.6809. Determination of Family Contribution for the Program.

(a) Family child contributions for the program shall consist of one of the following:

(1) A flat fee in each county for a family value package:

(A) Seven dollars ($7) per subscriber child with a maximum required contribution of fourteen dollars ($14) per month for subscriber children with annual household incomes after income deductions of up to and including 150 percent of the federal poverty level.

(B) Through ~~June 30, 2005~~ January 31, 2009, nine dollars ($9) per subscriber child with a maximum required contribution of twenty-seven dollars ($27) per month for subscriber children with annual household incomes after income deductions greater than 150 percent and up to and including ~~250~~ 200 percent of the federal poverty level; these rates are also applicable for subscribers who entered the program as AIM infants. On and after ~~July 1, 2005, these rates apply only for~~ February 1, 2009, twelve dollars ($12) per subscriber ~~children with annual household incomes after income deductions greater than 150 percent and up to and including 200 percent of the federal poverty level~~ child with a maximum required contribution of thirty-six dollars ($36) per month.

(C) ~~On and after July 1, 2005~~ Through January 31, 2009, fifteen dollars ($15) per subscriber child with a maximum required contribution of forty-five dollars ($45) per month for subscriber children with annual household incomes after income deductions greater than 200 percent and up to and including 250 percent of the federal poverty level; these rates are also applicable, through the first year of eligibility, for subscribers who entered the program as AIM infants and for those AIM infants whose annual household income after

deductions remains above 200 percent of the federal poverty level after each Annual Eligibility Review. On and after February 1, 2009, seventeen dollars ($17) per subscriber child with a maximum required contribution of fifty-one dollars ($51) per month.

(2) A flat fee in each county for a family value package that includes a community provider plan:

(A) Four dollars ($4) per subscriber child with a maximum required contribution of eight dollars ($8) per month for subscriber children with annual household incomes after income deductions of up to and including 150 percent of the federal poverty level.

(B) Through ~~June 30, 2005~~ January 31, 2009, six dollars ($6) per subscriber child with a maximum required contribution of eighteen dollars ($18) per month for subscriber children with annual household incomes after income deductions of greater than 150 percent and up to and including ~~250~~ 200 percent of the federal poverty level; these rates are also applicable for subscribers who entered the program as AIM infants. On and after ~~July 1, 2005~~ February 1, 2009, nine dollars ($9) per subscriber child with a maximum required contribution of twenty-seven dollars ($27) per month. ~~, these rates apply only for subscriber children with annual household incomes after income deductions greater than 150 percent and up to and including 200 percent of the federal poverty level.~~

(C) ~~On and after July 1, 2005~~ Through January 31, 2009, twelve dollars ($12) per subscriber child with a maximum required contribution of thirty-six ($36) per month for subscriber children with annual household incomes after income deductions of greater than 200 percent and up to and including 250 percent of the federal poverty level; these rates are also applicable, through the first year of eligibility, for subscribers who entered the program as AIM infants and for those AIM infants whose annual household income after income deductions remains above 200 percent of the federal poverty level after each Annual Eligibility Review. On and after February 1, 2009, fourteen dollars ($14) per subscriber

child with a maximum required contribution of forty-two dollars ($42) per month.

(b) Family parent contributions for the program shall consist of one of the following:

(1) A flat fee in each county for a family value package:

(A) Ten dollars ($10) per month per subscriber parent with an annual household income after income deductions of up to and including 150 percent of the federal poverty level.

(B) Twenty dollars ($20) per month per subscriber parent with an annual household income after income deductions greater than 150 percent and up to and including 200 percent of the federal poverty level.

(2) A flat fee in each county for a family value package that includes a community provider plan:

(A) Seven dollars ($7) per month per subscriber parent with an annual household income after income deductions of 150 percent of the federal poverty level.

(B) Seventeen dollars ($17) per subscriber parent with an annual household income after income deductions of greater than 150 percent and up to and including 200 percent of the federal poverty level.

(c) Applicants who pay in advance the amount of three (3) months of family child contributions shall receive the fourth consecutive month of coverage for a subscriber child with no family child contributions required.

(d) Applicants who pay in advance the amount of three (3) months of family parent contributions shall receive the fourth consecutive month of coverage for a subscriber parent with no family parent contributions required if the subscriber child contributions (if applicable) are also paid in advance, at the same time for the same three month period.

(e) Applicants who pay the family child contributions (if applicable) and the family parent contributions (if applicable) by electronic fund transfer or scheduled credit card payment shall receive a twenty-five (25) percent

discount off the monthly combined total of the family child contributions and family parent contributions.

(f) If the applicant is applying for children in more than one household, the income of the household with the lowest annual income after income deductions will be used to determine the family contributions.

(g) If an applicant has a family contribution sponsor, family child contributions and/or family parent contributions that are to be paid by the family contribution sponsor for any twelve (12) consecutive months in the program shall be established based on subsections (a) and (b) above.

(h) If an AIM infant is enrolled in a different health plan from his or her siblings until the Open Enrollment period after the AIM infant's first birthday, the family child contribution will be the family child contribution for the siblings, plus the contribution rate for one more child at the same rate, up to the maximum required contribution.

NOTE: Authority cited: Sections 12693.21 and 12693.755, Insurance Code.
Reference: Sections 12693.21, 12693.43, 12693.53 and 12693.755, Insurance Code.